NW
PJH

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

PJH

John Good T82633
(Name of Plaintiff)
E-1-88 PO Box 1050
(Address of Plaintiff)
Soledad CA 93960
SALINAS VALLEY STATE PRISON

CV 08 3285 PJH
(Case Number)

COPIED AT STATE EXPENSE
COPIER #00426

vs.

COMPLAINT

C/O Borroso
RN Mike Barker
DR. Robert Bowman
(Names of Defendants)

COPIED AT STATE EXPENSE

I. Previous Lawsuits:

A. Have you brought any other lawsuits while a prisoner: ☒ Yes ☐ No

B. If your answer to A is yes, how many?: 2 Describe the lawsuit in the space below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper using the same outline.)

Salinas Valley State Prison

1. Parties to this previous lawsuit:

Plaintiff John Good

Defendants Dept of Correction

2. Court (if Federal Court, give name of District; if State Court, give name of County)

Los Angeles Calif Civil suit ?

3. Docket Number ?

4. Name of judge to whom case was assigned ?

5. Disposition (For example: Was the case dismissed? Was it appealed? Is it still pending?)

PENDING

6. Approximate date of filing lawsuit 6-11-08

7. Approximate date of disposition ?

II. Exhaustion of Administrative Remedies

A. Is there a grievance procedure available at your institution? ☒ Yes ☐ No

B. Have you filed a grievance concerning the facts relating to this complaint? ☒ Yes ☐ No

If your answer is no, explain why not

C. Is the grievance process completed? ☐ Yes ☒ No

III. Defendants

(In Item A below, place the full name of the defendant in the first blank, his/her official position in the second blank, and his/her place of employment in the third blank. Use item B for the names, positions and places of employment of any additional defendants.)

A. Defendant C/O BORROSO is employed as CORRECTIONAL OFFICER at SILINAS VALLEY STATE PRISON

B. Additional defendants RN MIKE BARKER Registered NURSE SILINAS STATE PRISON PO BOX 1050 SOLEDAD CA 93960

MD ROBERT BOWMAN Doctor SILINAS VALLEY STATE PRISON PO BOX 1050 SOLEDAD CA 93960

IV. Statement of Claim

(State here as briefly as possible the facts of your case. Describe how each defendant is involved, including dates and places. Do not give any legal arguments or cite any cases or statutes. Attach extra sheets if necessary.)

(1) ON 3-4-08 I WAS housed IN A UPPER BUNK (2) ON 4-7-08 I FELL BACKWARDS AND hit my head, NECK, BACK (3) ON 4-7-08 I WENT INTO MEDICAL with SYMPTOMS I Told C/O BORROSO AND RN MIKE BARKER that felt like A STROKE (4) C/O BORROSO Told me To fill out A MEDICAL REQUEST AND WAIT MY TURN LIKE EVERYOONE ELSE (5) RN MIKE BARKER STATED IT WAS PROBLEY A pinched NERVE TO HANG upside DOWN FROM THE pull up BARS IT WOULD FIX IT (6) I WENT TO MEDICAL EVERY DAY FOR 10 DAYS BEFORE I SEEN A DOCTOR (7) ON THE 2ND DAY I WENT INTO MEDICAL TO SEE THE DR C/O BORROSO SAID WAIT MY TURN AND IF I DIDNT LIKE IT HE C/O BORROSO SLAMED A 602 GRIEVENCE ON HIS DESK AND STATED YOUR THE 602 KING V. Relief. 602 IT YOU 602 EVERYTHING ELSE AND I STILL DID NOT GET TO SEE THE DOCTOR

(State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no cases or statutes.)

(1) COMPENSATORY DAMAGES TO PAY FOR SURGERYS AND AFTER CARE BECAUSE CDCR STAFF WAS NEGLIGENT BY PUTTING ME IN AN UPPER BUNK WITCH CAUSED THE ACCEDENT TO MY INJIRYS AND PAIN AND SUFFERING, WITCH IS CRUEL AND UNUSEALL BECAUSE THEY CDCR REFUSES ME THE SURGERY I NEED TO NOT BE IN PAIN (2) PUNITIVE DAMAGES BECAUSE THE DEFENDENTS ACTED WITH EVIL MOTIVES OR INTENT BY NOT LETTING ME SEE THE DOCTOR FOR 10 DAYS AFTER I HAD THE FALL WITCH WAS RECKLESS OR CALLOUS INDIFFERENCE VIOLATEING MY CONSTITUTIONAL EIGTH AMENDMENT TO ADEQUATE MEDICAL CARE

Signed this 29 day of JUNE, ~~29~~ 2008

John Good
(Signature of Plaintiff)

I declare under penalty of perjury that the foregoing is true and correct.

6-29-08
(Date)

John Good
(Signature of Plaintiff)

Salinas Valley State Prison

COPY

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Facts sheet

Attchment 1

(8) SENCE CDCR HERE AT SILINAS VALLEY STATE PRISON HAS DENIGHED ME THE SURGERY TO WITCH DAMAGED MY C-SPINE C-5 THREW C-7 MY SYMPTOMS HAVE GROWN WORSE

(9) DR SHERER AT MONTEREY COMMUNITY HOSPITAL OF MONTEREY SAID WITH THE SURGERY IT WOULD RELIVE THE PRESURE ON MY C-SPINE AND IT WOULD RELIVE THE PAIN I FEEL

(10) MY PAIN LEVEL IS BEYOND A #10 IN THE PAIN SCALE

(11) I FEEL CDCR WAS RESPONCIBLE FOR PUTTING ME ON A TOP BUNK WHEN IN FACT THEY KNEW IVE HAD A SIZEURE DISORDER FROM THE 1990'S

(12) CDCR HAS A DELIBERATE INDIFFERENCE TO DR SHERER AT THE HOSPITAL BECAUSE I WAS TO PAROLE IN 70 DAYS

(13) MY MEDICAL CONDITION IS SERIOUSE CAUSE ITS LEFT ME DISABLED ON MY RIGHT SIDE FACE ARM, LEG, NECK

(14) IM UNABLE TO SIT UP RIGHT TO LONG CAUSE I SEE SPOTS AND BLACK OUT

(15) I CAN NOT STAND BECAUSE I HAVE NO SENCE OF BALLANCE

(16) SENCE IVE BEEN HERE AT SVSP I HAVENT BEEN ABLE TO GET ADEQUATE MEDICAL CARE FOR MY MEDICAL NEEDS

(17) EVE ADA FORMS THEY GRANT BUT YOU NEVER RECIVE WHAT THEY GRANT YOU

(18) INMATE GREVIENCE FORMS 602 DONT HELP WITH THE TREATMENT YOU NEED

Salinas Valley State Prison

COPY

State of California, Department of Corrections -- Institution: Salinas Valley State Prison

INTERDISCIPLINARY PROGRESS NOTES

Original To: ☐ DMH ☐ HRC | Copy Computer | Book Fax

Yard Called @ Spoke to:

RETURN FROM OFFSITE OR HOSPITAL

Returning From: ☐ NMC ☐ SVMH ☑ Other chomp | Referring PCP[SVSP] Pajons
Reason: ☐ ER ☐ Surgery ☑ Inpatient ☐ F/U
☐ Consult ☐ Dx Test ☐ Procedure | Speciality Provider: Chomp
RFS Returned: ☐ Yes ☑ No Completed ☐ Yes ☑ No | Requested Service: cvat R/O stroke
RFS Signed by Receiving Nurse: ☐ Yes ☑ No | Inmate Advised of PCP Follow-up: ☑ Yes ☐ No
Discharge Notes: ☑ Yes ☐ No incomplete | Meds Provided: ☐ Yes ☐ No ☑ Ordered
Receiving MD: Schere/Pajons Time called: | Report Received: ☑ To Follow: ☐ incomplete needs bank
Orders Rec'd: ☑ Yes ☐ No Faxed to Yard: ☑ Yes ☐ No | Housing Consistant with Needs: ☐ Yes ☑ No
UM Tracking Number: / per MD Schere | FOLLOW-UP WITH PCP PRIOR TO: 4/21/08

NURSING NOTES

Date: 4/19/08 Time in: 1900 Time out: 1945 | Mode of Arrival ☐ Walk ☑ W/C ☐ Other
Language Spoken: ☑ English ☐ Spanish- [Translator Used] ☐ Other [Translator Used]

Allergies: NKA Vital Signs: T 98.7 P 70 BP 136/87 R 14 O2 Sat 99 Pain Level 0 /10

ASSESSMENT:

A/Ox3 asking about meds renewal, instructed he would be brought 4 for meds, Pt concerned about C-spine will be seen by MD Bowman

SPECIALITY FINDINGS: ☐ Notes difficult to read ☒ able to read notes ☐ No findings listed

CT scan MRI completed 4/18/08 – limited study due to pt motion
no evidence of stroke, growth, or hemorrhage
C-Spine – spinal stenosis C5-C7

SPECIALITY RECOMMENDATIONS: ☐ F/U with Outside Provider ☐ Labs ordered in ER

Orders received from MD Schere
F/U 4/21/08
↑ to CTC for meds 4/20/08 AM

RN Signature:

RECEIVED
APR 21 2008

Last Name: Wood First Name: John MI:
CDC #: T-82633 DOB: / /
Housing: Date: 4/19/08

INTERDISCIPLINARY PROGRESS NOTES
7230[Rev 04/03] State of California Department of Corrections

chart not available

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DATE	TIME
4/21/08	
BP	114/78
P	74
R	18
T	98.4
Wt.	203

S) Returns from hospitalization to R/O stroke. It is their (CHOCP) opinion that all of his present symptoms are residual to the incident 2 years ago. There is no indication of a new CVA. Patient states he has more weakness in (R) arm + leg, more global headache pain + more instability.

O) Unchanged from several days ago.

(b) facial weakness - mouth pulled to (R).

Weakness of grasp (R) hand.

Weakness (R) arm + leg -

Still indicate (R) hemiparesis.

A) (R) hemiparesis, secondary to CVA

P) Will provide a walking cane.

Instructions written by Dr Schram, HPC.

Will follow in clinic - Parole in 7 days

INSTITUTION: SVSP | HOUSING UNIT: E1-77 | CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH: Good, John T82633

INTERDISCIPLINARY PROGRESS NOTES

8-2-61

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS

COMPREHENSIVE ACCOMMODATION CHRONO

134

INSTRUCTIONS: A physician shall complete this form if an inmate requires an accommodation due to a medical condition. Circle P if the accommodation is to be permanent, or T if the accommodation is to be temporary. If the accommodation is temporary, write the date the accommodation expires on the line. A new form shall be generated when a change to an accommodation is required or upon renewal of a temporary accommodation. Any new form generated shall include previous accommodations, if they still apply. Chronos indicating permanent accommodations shall be reviewed annually. This form shall be honored as a permanent chrono at all institutions.

A. HOUSING

None		Bottom Bunk	(P) / T
Barrier Free/Wheelchair Access	P / T	Single Cell (See 128-C date:)	P / T
~~Ground Floor Cell~~	(P) / T	Permanent OHU / CTC (circle one)	P / T
Continuous Powered Generator	P / T	Other	P / T

B. MEDICAL EQUIPMENT/SUPPLIES

None		Wheelchair: (type)	P / T
Limb Prosthesis	P / T	Contact Lens(es) & Supplies	P / T
Brace	P / T	Hearing Aid	P / T
Crutches	P / T	Special Garment:	
Cane: (type)	(P) / T NEED	(specify)	P / T
Walker	P / T	Rx. Glasses:	P / T
Dressing/Catheter/Colostomy Supplies	P / T	Cotton Bedding	P / T
Shoe: (specify)	P / T	Extra Mattress	P / T
Dialysis Peritoneal	P / T	Other	P / T

C. OTHER

None		Therapeutic Diet: (specify)	P / T
Attendant to assist with meal access and other movement inside the institution.	P / T	Communication Assistance	P / T
Attendant will not feed or lift the inmate/patient or perform elements of personal hygiene.		Transport Vehicle with Lift	P / T
		Short Beard	P / T
Wheelchair Accessible Table	P / T	Other	P / T

D. PHYSICAL LIMITATIONS TO JOB ASSIGNMENTS

Based on the above, are there any physical limitations to job assignments? ☒ Yes ☐ No

If yes, specify: Wedges, (R) Cane + leg.

INSTITUTION: SVSP	COMPLETED BY (PRINT NAME): BOWMAN	TITLE: MD
SIGNATURE: Robert Bowman MD	DATE: 4/21/08	CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH: GOOD, JOHN T52633 EL 775
HCM/CMO SIGNATURE:	DATE: 4/22/08	
(CIRCLE ONE) APPROVED / DENIED	Copy to: Work Supervisor	

COMPREHENSIVE ACCOMMODATION CHRONO

CDC 7410 (03/04)

Distribution: Original - Unit Health Record Canary - Central File Pink - Correctional Counselor Gold - Inmate

COMPREHENSIVE ACCOMMODATION CHRONO

133

INSTRUCTIONS: A physician shall complete this form if an inmate requires an accommodation due to a medical condition. Circle P if the accommodation is to be permanent, or T if the accommodation is to be temporary. If the accommodation is temporary, write the date the accommodation expires on the line. A new form shall be generated when a change to an accommodation is required or upon renewal of a temporary accommodation. Any new form generated shall include previous accommodations, if they still apply. Chronos indicating permanent accommodations shall be reviewed annually. This form shall be honored as a permanent chrono at all institutions.

A. HOUSING

None		~~Lower Bunk~~	(P) / T
Barrier Free/Wheelchair Access	P / T	Single Cell (See 128-C date:)	P / T
~~Ground Floor Cell~~	(P) / T	Permanent OHU / CTC (circle one)	P / T
Continuous Powered Generator	P / T	Other	P / T

B. MEDICAL EQUIPMENT/SUPPLIES

None		Wheelchair: (type)	P / T
Limb Prosthesis	P / T	Contact Lens(es) & Supplies	P / T
Brace	P / T	Hearing Aid	P / T
Crutches	P / T	Special Garment:	
~~Cane: (type)~~	(P) / T NEED	(specify)	P / T
Walker	P / T	Rx. Glasses:	P / T
Dressing/Catheter/Colostomy Supplies	P / T	Cotton Bedding	P / T
Shoe: (specify)	P / T	Extra Mattress	P / T
Dialysis Peritoneal	P / T	Other	P / T

C. OTHER

None		Therapeutic Diet: (specify)	P / T
Attendant to assist with meal access and other movement inside the institution.	P / T		
Attendant will not feed or lift the inmate/patient or perform elements of personal hygiene.		Communication Assistance	P / T
		Transport Vehicle with Lift	P / T
		Short Beard WAIST RESTRAINTS	P / T
Wheelchair Accessible Table	P / T	Other	(P) / T

D. PHYSICAL LIMITATIONS TO JOB ASSIGNMENTS

Based on the above, are there any physical limitations to job assignments? ☒ Yes ☐ No

If yes, specify: NO ~~PROLO~~ EXTENDED WALKING OR PROLONGED STANDING

INSTITUTION	COMPLETED BY (PRINT NAME)	TITLE
SVSP	BOWMAN	MD
SIGNATURE	**DATE**	**CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH**
Robert Bowman MD	4/21/08	GOOD T 82633
HCM/CMO SIGNATURE	DATE	
(CIRCLE ONE) APPROVED / DENIED	Copy to: Work Supervisor	

COMPREHENSIVE ACCOMMODATION CHRONO

CDC 7410 (03/04)

Distribution: Original - Unit Health Record Canary - Central File Pink - Correctional Counselor Gold - Inmate

120

- THERAPY DIAGNOSIS (Impairment): Activites of Daily Living, Balance, Gait, Posture/biomechanics, Range of motion, Strength, Transfer/mobility status

PERSONAL/FAMILY/SOCIAL HISTORY

LIVING SITUATION

CURRENT RESIDENCE: correctional facility

STAIRS

STAIRS: No stairs

ACTIVITY HISTORY

INDEPENDENT ACTIVITY: performs ADL's independently

- FALL HISTORY: 1-3 falls in last year, fell backwards from bunk

PATIENT ORIENTATION

- ORIENTED TO: Person Place Time Situation

NARRATIVE

- NARRATIVE: Pt is a 46 year old male admitted on 4/17 for possible CVA and Right sided weakness. Pt has past medical history of prior CVA '05 with Right sided weakness, hypertension and Hepatitis C. Pt lives at a correctional facility and had 2 guards in the room throughout the evaluation. Today pt had ROM and sensation deficits on Right upper extremity and lower extremity. Pt was independent with bed mobility and required stand by assist with sit <-> stand transfers. Pt with complaints of slight dizziness upon standing. Pt able to take 2x5 steps forward/back with front wheeled walker and contact guard assist. Pt returned to bed with guards in room. Anticipate pt will be able to return to correctional facility upon discharge.

SUBJECTIVE

- PATIENT STATEMENT: "When this happened to me last time, in '05, it took me about a year before my balance was good enough to not use a cane."

CARDIOPULMONARY

BLOOD PRESSURE

- SITTING...SYSTOLIC: 159 mm Hg
- ...DIASTOLIC: 92 mm Hg
- PATIENT RESPONSE: Dizzy, slightly increased with standing

OXYGEN

- ...O2 PER: Room air
- ...SATURATION-INITIAL (RESTING): 97 %
- ...SATURATION-POST 96 %

ACTIVITY:

HEART RATE

- ...INITIAL (RESTING):	74 bpm

PAIN ASSESSMENT

PAIN ASSESSMENT

- ...INTENSITY (0-10 SCALE):	did not rate
- ...FREQUENCY:	frequent
- ...LOCATION:	RUE, RLE

PAIN GOAL/STATUS

- GOAL...INTENSITY with movement, work, ADLs, mobility and exercise:	0/10

NEUROMUSCULAR SCREENING

MANUAL MUSCLE TEST

ASSESSMENT:	Within functional limits except the following:
C3-4, CN11 (Shoulder shrug)...RIGHT:	5
C3-4, CN11 (Shoulder shrug)...LEFT:	3
C5 (Deltoid)...RIGHT:	4-
C5 (Deltoid)...LEFT:	5
C5-6 (Biceps)...RIGHT:	3+
C5-6 (Biceps)...LEFT:	5
C6 (Wrist Extensors)...RIGHT:	3+
C6 (Wrist Extensors)...LEFT:	5
C7 (Wrist Flexors)...RIGHT:	3+
C7 (Wrist Flexors)...LEFT:	5
C7-8 (Triceps)...RIGHT:	3+
C7-8 (Triceps)...LEFT:	5
C8 (FDS/FDP/Thumb Extension)...RIGHT:	3+
C8 (FDS/FDP/Thumb Extension)...LEFT:	5
T1 (Hand intrinsics/interossei)...RIGHT:	3+
T1 (Hand intrinsics/interossei)...LEFT:	5
L1-2 (Hip Flexion)...RIGHT:	4
L1-2 (Hip Flexion)...LEFT:	5
L3 (Knee Extension)...RIGHT:	4
L3 (Knee Extension)...LEFT:	5
L4 (Ankle Dorsiflexion)...RIGHT:	3+
L4 (Ankle Dorsiflexion)...LEFT:	5
L4-5 (Ankle Inversion)...RIGHT:	3+
L4-5 (Ankle Inversion)...LEFT:	5

L5 (Extension Hallucis Longus)...RIGHT:	3+
L5 (Extension Hallucis Longus)...LEFT:	5

ROM SCREENING

ASSESSMENT:	Within functional limits except the following:
RLE:	Pain limiting AROM

SENSATION SCREENING

ASSESSMENT:	Within functional limits except the following:
C4 (Lateral Neck/Supraclavicular Area) ...RIGHT:	Hypothesia
...LEFT:	Normal
C5 (Lateral Upper Arm) ...RIGHT:	Hypothesia
...LEFT:	Normal
C6 (Ventral/Lateral Lower Arm/Fingers 1,2) ...RIGHT:	Hypothesia
...LEFT:	Normal
C7 (Dorsum or Arm/Finger 3) ...RIGHT:	Hypothesia
...LEFT:	Normal
C8 (Medial Hand/Fingers 4,5) ...RIGHT l-rs-sensation-kh-s:	Hypothesia
...LEFT:	Normal
T1 (Medial/Ulnar Arm) ...RIGHT:	Hypothesia
...LEFT:	Normal
L2 (Anterior/Medial/Proximal Thighs ...RIGHT:	Hypothesia
...LEFT:	Normal
L3 (Knees/Medial Thighs/Medial LE) ...RIGHT:	Hypothesia
...LEFT:	Normal
L4 (Lateral LE/Medial-dorsum Foot/Big Toe) ...RIGHT:	Hypothesia
...LEFT:	Normal
L5 (Lateral LE/Dorsum Foot) ...RIGHT:	Hypothesia
...LEFT:	Normal
S1 (Lateral Side Foot/Posterior LE) ...RIGHT:	Hypothesia
...LEFT:	Normal

PROPRIOCEPTION/COORDINATION

ASSESSMENT:	Within functional limits

CRANIAL NERVE SCREENING

NERVE #3 EYE MUSCLES/MOVEMENT

- RIGHT EYE/UP	Intact
- RIGHT EYE/MEDIAL	Intact
- LEFT EYE/UP	Intact
- LEFT EYE/MEDIAL	Intact

NERVE #4 SUPERIOR OBLIQUE

- RIGHT EYE/DOWN and LATERAL	Intact
- LEFT EYE/DOWN and LATERAL	Intact

NERVE #5 FACIAL SENSATION

- LEFT/LIGHT TOUCH	Intact
- RIGHT/LIGHT TOUCH	Impaired

NERVE #6 LATERAL RECTUS

- RIGHT EYE/LATERAL	Intact
- LEFT EYE/LATERAL	Intact

NERVE #7 FACIAL MUSCLES

- CLOSE EYES TIGHT	Intact
- RAISE EYEBROWS	Intact
- SMILE	Impaired
- ...	Right
- PUFF CHEEKS	Impaired
- ...	Right

NERVE #11 RESISTED SHOULDER SHRUG

- RIGHT SHOULDER	Intact
- LEFT SHOULDER	Impaired

NERVE #12 TONGUE PROTRUSION

- PROTRUSION	Impaired
- ...	Veers right

BED MOBILITY

BED MOBILITY ASSIST

- ROLLING TO RIGHT:	Independent
- ROLLING TO LEFT:	Independent
- SUPINE TO SIT:	Independent
- SIT TO SUPINE:	Independent

BED MOBILITY GOAL/STATUS

- ASSIST In and out of bed with proper body mechanics:	Independent

SITTING BALANCE ASSESSMENT

STATIC

UNSUPPORTED ASSESS:	Safe/Independent
UNSUPPORTED:	2 min
SUPPORTED ASSESS:	Safe/Independent
SUPPORTED:	5 min
independent (BERG=2 min):	Yes
independent (BERG=no hands):	No
independent (BERG=minimal hands):	Yes
- (MODIFIED) BERG INDEPENDENT SITTING SCORE (max=4):	3
- SCORE ASSESSMENT:	Fair plus, requires supervision

STANDING BALANCE ASSESSMENT

STATIC

UNSUPPORTED, EYES OPEN:	Unsteady
UNSUPPORTED:	1 min
independent (BERG=2 min):	No

UNSUPPORTED, EYES CLOSED:	Loss of balance/Need assistance
UNSUPPORTED:	3 sec
- SCORE ASSESSMENT:	Poor, unsafe

TRANSFERS

TRANSFER ASSIST

- SIT TO STAND:	Stand-by Assist
- STAND TO SIT:	Stand-by Assist

TRANSFERS GOAL/STATUS

- ASSIST from sit to stand and transfer to chair, commode, bed:	Independent

GAIT TRAINING

AMBULATION

- WEIGHT BEARING STATUS:	Weight bearing as tolerated
- DISTANCE (feet):	2x5 forward/back
- SURFACE TYPE:	Level
- GAIT PATTERN:	Partial Through
- GAIT TRAJECTORY:	No Deviation
- ASSISTIVE DEVICE:	Front wheeled walker
- ASSIST:	Verbal Cues, Contact Guard
- DIRECTION:	Forward/Backward
- GAIT DESCRIPTION:	Decreased right heel strike Forward lean
- NUMBER OF REST STOPS:	0

EDUCATION ASSESSMENT

- COMPREHENSION-CONCEPTS:	Good comprehension
- RESPONSIVENESS TO QUESTIONS:	Responsive
- MOTIVATION:	Asks questions, Willing to learn
- MEMORY:	No deficit identified
- LEARNING BARRIERS:	No barriers identified

PATIENT TEACHING

- PERSON(S) EDUCATED:	Patient
- TOPICS:	Assistive device/adaptive equipment usage, Behaviors that reduce condition recurrence, Disease/healing process, Gait training, Safety skills, Transfer skills
- METHOD/MATERIALS PROVIDED:	Verbal, Skill practice
- EDUCATION OUTCOMES:	Initiated instruction, Needs reinforcement

FUTURE INTERVENTION

- TREATMENT PLAN UPDATE:	Continue current treatment plan

PLAN OF TREATMENT

- FREQUENCY:	One time per day
- DURATION:	3-5 days
- INTERVENTIONS:	Activities of Daily Living Training, Assistive device training, Balance training, Gait training, Range of motion, Strengthening, Transfer training

I Also Filed A Staff Complaint Against C/O Borroso on 5-26-08 for misconduct Appeal Log # SVSP 08-2845 Category 7 Then on 6-27-08 after he was aware of The 602 Staff complaint against him while I was waiting in medical on The Doctor who didnt show C/O Borrosso Theatened me saying he felt like throwing me in the Hole Add Seg for Something Someone else said C/O Borroso made everyone leave medical Except me and one other person C/O Borroso Tryed saying I Theatened Him to Sgt Gonzales on 6-27-08 At 1:45 pm and He C/O Borroso stated if I Drop my Staff Complaint Against him I would only get a 128 B Chrono put in my file instead of Being Charged for Threating Staff To with I was not even in The other persons Conversation So I with Drew my Staff Complaint for fear of my well Being and freedom C/O Borroso Stated I ought To spray you with my peper spray and Stated To The fact he C/O Borroso could get away with it

Cont ⇒

~~IV~~ CONT

I PLAN. TO RESUBMIT MY STAFF COMPLAINT THE DAY BEFORE I LEAVE CAUSE IM AFFRAID FOR MY LIFE AND WELL BEING AND FOR MY FREEDOM I PAROLE JULY 8 2008 WILL SUBMIT IT AGAIN 7-7-08

JOHN GOOD T82633

I WOULD LIKE TO HAVE MY STAFF COMPLAINT FOLLOWED UP ON CAUSE I FEEL SILINAS VALLEY STATE PRISON WILL LOSE IT IVE MADE THE APPEAL OFFICE AWARE OF MY HOME ADDRESS OF AND AFTER JULY 8TH 2008 IS AS FOLLOWS

JOHN GOOD
201 N YUCCA AVE APT H-101
BARSTOW CA 92311

CETIFIED TRUST COPY IN

I John Aka Good would like to ask the courts to appoint me an Attorney to help me protect my rights violated By Prison officials By makeing me wait 10 Days After I had A fall To see A prison Doctor I stated To ~~Def~~ Defendent G Borroso and Defendent RN Mike Barker That I have The feeling of haveing A stroke Even After I told Both The Above Defendents. That I was not seen By The prison Doctor it still took 10 Days Before I seen The Doctor

Today 7-1-08 Has Been 45 Days To try and see The Doctor Ive put in 5 or 6 Request in 45 Days twice Ive gotten into medical But no Doctor ever showed up Today my condition has gotten 5 Times worse and Both The Above named Defendents could care less I came in Almost normal Today I cant stand, Hardly walk and if I Turn my head side ways I Black out

John Good

6-29-08

To Court Clerk

Please take notice that I John Good T82633 am incarcerated here at Salinas Valley State Prison Po Box 1050 Soledad Calif 93960 until July 8th 2008 after July 8th 2008 my mailing address will be as follows,

John Good
201 N Yucca Ave Apt H-101
Barstow Calif 92311 Mess # (760) 252 4194
or (760) 221-3136

Any and all mail after July 8 2008 please send to my Barstow CA. address

If I need to send any other forms or information please let me know I have all Doctors note, Hospital Reports, who said what The fall is Documentated the spinel injurys are noted along with Disabilitys, the Denighing me surgery cause I was 70 Days to parole was Documentated by the Doctors even The 10 Days it took to get to Doctor is all in my medical file To witch I have copys so any thing you need as proff please let me know

Certified Trust certificate in 2nd to last page other stapled copy

AO 440 (Rev. 5/85) Summons in a Civil Action

United States District Court

NORTHERN DISTRICT OF CALIF

John Good CDC# T82633

V.

SUMMONS IN A CIVIL ACTION

CASE NUMBER:

C/O BORROSO
RN MIKE BARKER
MD Robert Bowman

TO: (Name and Address of Defendant)
Calif Dept of Corrections, Silinas valley state prison
PO Box 1050 Soledad Calif 93960

YOU ARE HEREBY SUMMONED and required to file with the Clerk of this Court and serve upon

PLAINTIFF'S ATTORNEY (name and address)

an answer to the complaint which is herewith served upon you, within _____ days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

Salinas Valley State Prison

COPY

CLERK

DATE

BY DEPUTY CLERK

John Good T82633
E-1-88 PO Box 1050
Salinas Valley State Prison
Soledad CA 93960

UNITED STATES POSTAGE
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RICHARD W. WIEKING
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

To United States District Court
for Northern District Att Civil Rights Division
U.S. Court House
450 Golden Gate Ave
San Francisco CA
94102-3483

STATE PRISON
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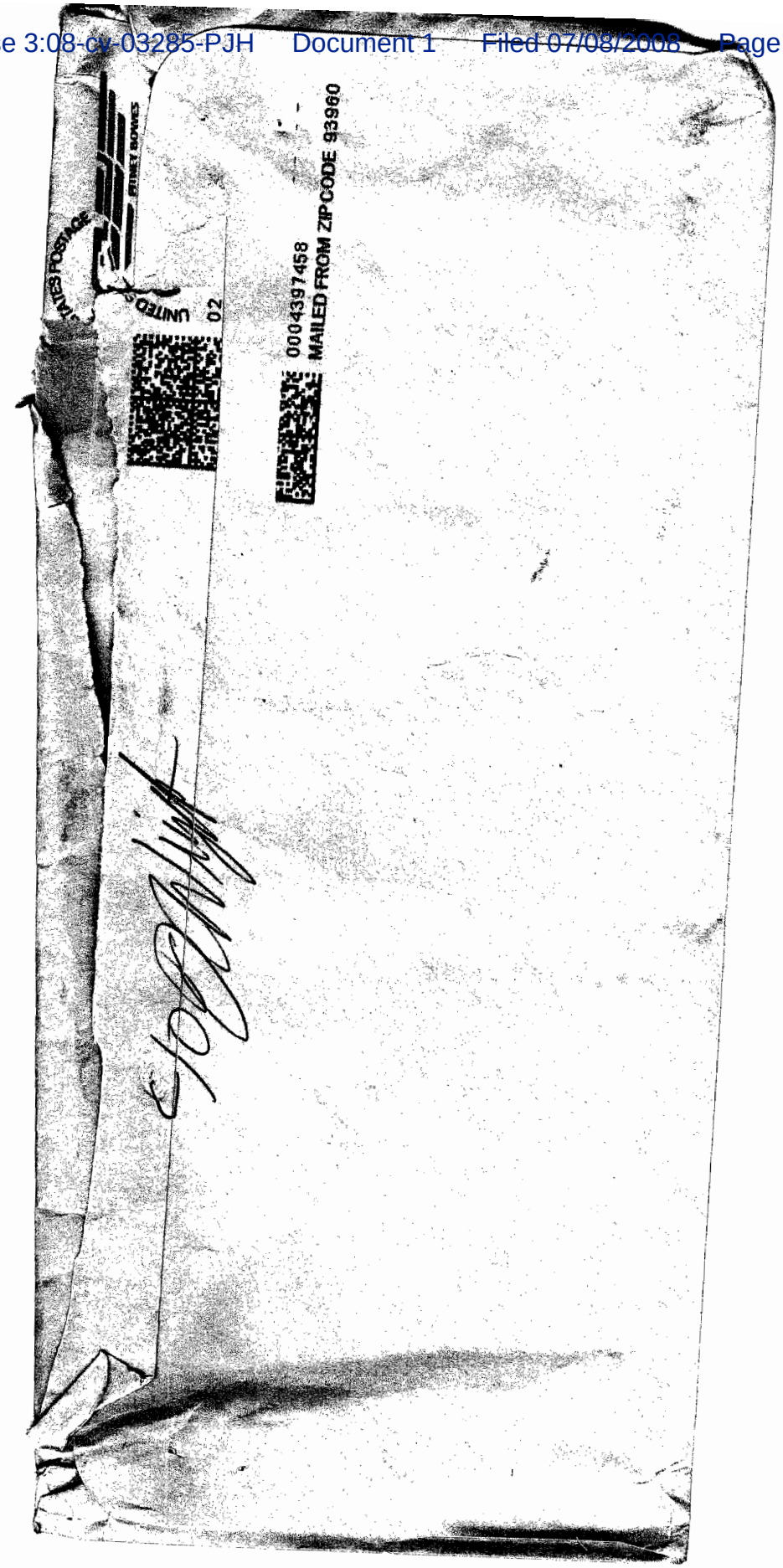
Legal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